ATTACHMENT 1
Prior Authorization Therapy Attachment Completion Instructions

(A copy of the Prior Authorization Therapy Attachment Completion Instructions is located on the following pages.)

PRIOR AUTHORIZATION/THERAPY ATTACHMENT COMPLETION INSTRUCTIONS

The Wisconsin Medicaid program requires information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02 (4), Wis. Admin. Code).

Under s. 49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

Each provider must submit sufficient detailed information. Sufficient detailed information on a PA request means enough clinical information regarding the recipient to meet Wisconsin Medicaid's definition of "medically necessary." "Medically necessary" is defined in HFS 101.03(96m), Wis. Admin. Code. Each PA request is unique, representing a specific clinical situation. Therapists typically consider a number of issues that influence a decision to proceed with therapy treatment at a particular frequency to meet a particular goal. Those factors that influence treatment decisions should be documented on the PA request. Medicaid therapy consultants will consider documentation of those same factors to determine whether or not the request meets Wisconsin Medicaid's definition of "medically necessary." Medicaid consultants cannot "fill in the blanks" for a provider if the documentation is insufficient or unclear. The necessary level of detail may vary with each PA request and within the various sections of a PA request.

These directions are formatted to correspond to each required element on the Prior Authorization Therapy Attachment (PA/TA). The **bold** headers directly reflect the name of the element on the PA/TA. The proceeding text reflects instructions, hints, examples, clarification, etc. that will help the provider document medical necessity in sufficient detail.

Attach the completed Prior Authorization Therapy Attachment (PA/TA) to the Prior Authorization Request Form (PA/RF) and submit to the following address:

Wisconsin Medicaid
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

SECTION A. RECIPIENT / PROVIDER INFORMATION

Enter the following information into the appropriate box:

1. **Recipient's Name — Last, First and MI**
   Enter the recipient's last name, first name, and middle initial. Use Wisconsin Medicaid's Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or the spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Refer to the Provider Resources section of the All-Provider Handbook for ways to access the EVS.
2. **Recipient's Medicaid ID Number**
   Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.
3. **Recipient's Age**
   Enter the age of the recipient in numerical form (e.g., 16, 21, 60).
4. **Therapist's Name & Credentials**
   Enter the treating therapist's name and credentials. If the treating therapist is a therapy assistant, enter the name of the supervising therapist and the name of the therapy assistant.

5. **Therapist's Medicaid Provider Number**
   Enter the treating therapist's eight-digit Medicaid provider number. If the treating therapist is the therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider number.
6. **Therapist's Telephone Number**
   Enter the treating therapist's telephone number, including area code and extension (if applicable). If the treating therapist is a therapy assistant, enter the telephone number of the supervising therapist.
7. **Referring/Prescribing Physician's Name**
   Enter the referring or prescribing physician's name.

   Be sure*:*
   - The recipient's name and Medicaid identification number match.
   - The recipient's Medicaid identification number has 10 digits.
   - The recipient is currently Medicaid eligible.
   - The provider's name and Medicaid identification number match.
   - The provider's Medicaid number has eight digits.

   HINT*:* All of this information in this section must be complete, accurate, and exactly the same as the information from Medicaid's EVS and on the Prior Authorization Request Form (PA/RF) before your PA request is forwarded to a Medicaid consultant. *Incomplete or inaccurate information will result in a returned PA request*.

8. **Requesting Prior Authorization (PA) For Physical Therapy Occupational Therapy Speech Therapy**
   Check the appropriate box on the PA/TA for the type of therapy service being requested.

9. **Total Time Per Day Requested**
   Enter the anticipated number of minutes a typical treatment session will require. It is expected the requested minutes per session will be consistent with the recipient's history, age, attention span, cognitive ability, medical status, treatment goals, procedures, rehabilitation potential and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

10. **Total Sessions Per Week Requested**
    Enter the number of treatment days per week requested. It is expected the requested number of treatment days per week will be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential and any other intervention the recipient receives. Intensity of intervention is determined by rate of change, rather than level of severity.

11. **Total Number of Weeks Requested**
    Enter the number of weeks requested. The requested duration should be consistent with the recipient's history, medical status, treatment goals, rehabilitation potential and any other intervention the recipient receives. The requested duration SHOULD CORRESPOND TO THE NUMBER OF WEEKS REQUIRED TO REACH THE GOALS IDENTIFIED IN THE PLAN OF CARE. Intensity of intervention is determined by rate of change, rather than level of severity.

12. **Requested Start Date**
    Enter the requested grant date for this PA request in MM/DD/YYYY format.

SECTION B. PERTINENT DIAGNOSES / PROBLEMS TO BE TREATED

INSTRUCTIONS: Provide a description of the recipient's current treatment diagnosis, any underlying conditions, and problem(s) to be treated, including dates of onset.

Indicate the pertinent, medical diagnoses that relate to the reasons for providing therapy for the recipient at this time AND any underlying conditions that may affect the plan of care or outcome (e.g., dementia, cognitive impairment,

medications, attention deficits). Include dates of onset for all diagnoses. If the date of onset is unknown, state "unknown."

If this documentation is on a previous PA request and is still valid, indicate "this documentation may be found on PA No. XXXXXXX." Providers should review this information for accuracy each time that they submit a PA request.

HINT: Avoid copying the same information on subsequent PA requests without verifying that the information continues to be accurate. A PA request may be returned if it appears as if there has been no change documented under Section B, but other sections of the PA suggest there have been some changes to the recipient's medical/functional condition/need.

Example 1: A recipient without cognitive impairment may attain a goal to learn a task in one to three visits. However achieving the same treatment goal for a cognitively impaired recipient may require additional visits. Knowledge of the recipient's cognitive abilities is critical to understanding the need for the requested additional visits.

Example 2: When the recipient has a medical diagnosis, such as Parkinson's disease or pervasive developmental disorder, it is necessary to document the medical diagnosis AS WELL AS the problem(s) being treated. Listing problem(s) to be treated without a medical diagnosis, or vice versa, is insufficient.

SECTION C. BRIEF PERTINENT MEDICAL / SOCIAL INFORMATION

INSTRUCTIONS: Include referral information, living situation, previous level of function, any change in medical status since previous PA request(s), and any other pertinent information.

The Medicaid consultant needs to understand the complete "picture" of the recipient and takes into consideration the recipient's background, personal needs, status, change in status, etc. Sufficient, but pertinent, documentation of a recipient's medical/social status *may* include:

- Conditions that may affect the recipient's outcome of treatment.
- Evidence that this recipient will benefit from therapy at this time.
- Reasons why a Medicaid-reimbursed service is being requested at this time (this is helpful when this is not a new diagnosis or is a continuing episode of care for this recipient).

The provider's documentation *must* include the factors considered when developing the recipient's plan of care. Such factors *may* be:

- Reasons for referral.
- Referral source (e.g., a second opinion, nursing having difficulty with carry-over program, school therapist referred because school does not have equipment to make orthotics).
- Reason(s) the recipient's medical needs are not met under current circumstances.
- Recent changes (e.g., change in medical status, change in living status) with reference dates.
- Recipient's goal (e.g., recipient's motivation to achieve a new goal may have changed).
- Recipient's living situation.
- Residence (e.g., nursing home vs. independent living).
- Caregiver (who is providing care [specific name not required], how frequently available, ability to follow through with instructions, etc.).
- If caregiver is required — the level of assistance required, the amount of assistance required, the type of assistance required.
- Degree of family support.
- Equipment and/or environmental adaptations used by the recipient.
- Brief history of the recipient's previous functional status.
- Prior level of function.
- Level of function after last treatment episode with reference dates.
- Cognition/behavior/compliance.
- Any other pertinent information that indicates a need for therapy services at this time.

SECTION D. PERTINENT THERAPY INFORMATION

1. **INSTRUCTIONS: Document the chronological history of treatment provided for the treatment diagnoses (identified under "B"), dates of those treatments, and the recipient's functional status following those treatments.**

   Summarize previous episodes of care, if applicable, in the chart provided in this section. If this is a new patient, include history taken from the recipient, recipient's caregivers, or patient file. Include knowledge of other therapy services provided to the recipient (e.g., if requesting a PA for speech-language pathology [SLP], include any occupational therapy [OT] or physical therapy [PT] the recipient may have received as well). Be concise, but informative.

2. **INSTRUCTIONS: List other service providers that are currently accessed by the recipient for treatment diagnoses identified under "B," (i.e., home health, school, behavior management, home program, dietary services, therapies. Briefly document the coordination of the therapy treatment plan with these other service providers. Documentation may include phone logs, summarization of conversations/written communication, copies of plans of care, staffing reports, received written reports, etc.**
   Document the coordination of the therapy treatment plan with other service providers that may be working to achieve the same, or similar, goals for the recipient. If there are no other providers currently treating the recipient, indicate "not applicable" in the space provided.

3. **INSTRUCTIONS: Check the appropriate box (on the PA/TA) and circle the appropriate form, if applicable:**

   - ☐ **The current Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP)/ Individual Program Plan (IPP) is attached to this PA request.**
   - ☐ **The current IEP/IFSP/IPP is attached to PA Number_____.**
   - ☐ **There is no IEP/IFSP/IPP because _____.**
   - ☐ **Co-treatment with another therapy provider is within the plan of care.**
   - ☐ **Referenced report(s) is attached (list any report[s])_____.**

   The IEP, IFSP, and IPP are reports used as follows:

   - Individualized Education Plan — A written plan for a 3- to 21-year-old child who receives exceptional education services in school.
   - Individualized Family Service Plan — A written plan for a 0- to 3-year-old child who receives therapy services through the Birth to Three Program.
   - Individualized Program Plan — A written active treatment plan for individuals who reside in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

   Submission of the IEP, IFSP, and IPP with the PA request is required if the recipient is receiving services that require one of the above written plans.

   This section is included as a quick reference to remind the provider to attach the necessary documentation materials to the PA request and to remind providers to document co-treatment, if applicable, in their plan of care.

   Co-treatment is when two therapy types provide their respective services to one recipient during the same treatment session. For example, OT and PT treat the patient at the same time or OT and SLP treat the recipient at the same time. It is expected the medical need for co-treatment be documented in *both* providers' plans of care and *both* PA requests are submitted *in the same envelope*.

   Other "referenced reports" may be swallow studies, discharge summaries, surgical reports, dietary reports, psychology reports, etc. These reports should be submitted with the PA request when the information in those reports influenced the provider's treatment decision making and were referenced elsewhere in the PA request. PA requests submitted without the required or referenced documentation attached to the PA request will be returned to the provider.

SECTION E. EVALUATION (COMPREHENSIVE RESULTS OF FORMAL / INFORMAL TESTS AND MEASUREMENTS THAT PROVIDE A BASELINE FOR THE RECIPIENT'S FUNCTIONAL LIMITATIONS)

INSTRUCTIONS: Attach a copy of the initial evaluation, or the most recent evaluation or re-evaluation; or indicate with which PA number this information was previously submitted.

- ☐ **Comprehensive initial evaluation attached. Date of initial comprehensive evaluation _____.**
- ☐ **Comprehensive initial evaluation submitted with PA number _____.**
- ☐ **Current re-evaluation attached. Date of most current evaluation or re-evaluation(s) _____.**
- ☐ **Current re-evaluation submitted with PA number _____.**

A copy of the comprehensive evaluation for the current episode of care (for the current problem being treated) must be included with the PA request or submitted previously with another PA request, regardless of when treatment was initiated, and regardless of the reimbursement source at the time of the comprehensive evaluation. An evaluation defining the recipient's overall functional abilities and limitations with baseline measurements, from which a plan of care is established, is necessary for the Medicaid consultant to understand the recipient's needs and the request.

The initial evaluation must:

(1) Establish a baseline for identified limitations — Provide baseline measurements that establish a performance (or ability) level, *using units of objective measurement that can be consistently applied when reporting subsequent status*. It is very important to use consistent units of measurement throughout documentation, or be able to explain why the units of measurement changed.

Example 1: If the functional limitation is "unable to brush teeth," the limiting factor may be due to strength, range of motion, cognition, sensory processing, equipment needs, etc. The baseline should establish the status of identified limiting factors. Such factors may include:

- Range of motion measurements in degrees;
- Eye-hand coordination as measured by a testing tool or units of speed and accuracy;
- Oral sensitivity as measured by an assessment tool or type of reaction to specific kinds of textures, temperatures at specific oral cavity/teeth location;
- Grasp deficits including type of grasp and grip strength.

Later on, subsequent progress must be described using the same terms (e.g., grip strength increased by 2 pounds).

Example 2: If the functional limitation is "unable to sit long enough to engage in activities," indicate "the recipient can short sit for two minutes, unsupported, before losing his balance to the left." Later on, progress can be documented in terms of time.

(2) Relate the functional limitations to an identified deficit — The evaluation must be comprehensive enough that another, independent, clinician would reasonably reach the same conclusion regarding the recipient's functional limitation.

Example 1: The recipient is referred to therapy because "she doesn't eat certain types of foods." The evaluation should clearly indicate the reason for not eating those certain foods. A deficit has not been identified if testing indicates the recipient only eats Food "B." Some deficit examples (for not eating a variety of foods) are: cleft palate, oral defensiveness, lip closure, tongue mobility, an aversion to food, aspiration, attention span, recipient is G-tube fed and is therefore not hungry. The identified deficit must be objectively measured and quantified (i.e., a baseline — see above).

Example 2: The recipient is referred to therapy because "he cannot go up and down stairs safely." The evaluation should clearly indicate the reasons for this functional limitation. A deficit has not been identified if the results of testing indicate the recipient can only step up three inches. Strength, range of motion,

balance, sensory processing, motivation, etc., must be assessed and documented to identify the deficit causing the functional limitation (objectively tested, measured and quantified on the evaluation).

A re-evaluation is the process of performing selected tests and measures (after the initial evaluation) in the targeted treatment area(s) to evaluate progress, functional ability, treatment effectiveness, and/or to modify or redirect intervention. The re-evaluation must be submitted with the PA request whenever it is necessary to update the recipient's progress/condition. Use of the same tests and measurements as used in the initial evaluation is essential to review status/progress. If new tests or measurements are used in the re-evaluation, explain why a different measurement tool was used.

SECTION F. PROGRESS

INSTRUCTIONS: Describe progress in specific, measurable, objective, and functional terms (using consistent units of measurement) that are related to the goals/limitations, *since treatment was initiated or last authorized*.

(If this information is concisely written in other documentation prepared for your records, attach and write "see attached" in the space.)

Document the goal or functional limitation in the left column on the PA/TA. Indicate the corresponding status for that goal or limitation *as of the previous PA request or since treatment was initiated (whichever is most recent)* in the middle column on the PA/TA. Indicate the corresponding status of that goal or limitation *as of the date of the current PA request* (do not use "a month ago" or "when last seen" or "when last evaluated") in the third column of the PA/TA. Progress relates to the established baseline, previous goals, and identified limitations. Use the same tests and measurements as those units of measurement used in the baseline description.

The following information is necessary to evaluate the medical necessity of the PA request:

- Progress documented in specific, measurable, objective terms.
- Use of words that are specific, measurable, or objective such as: better, improved, calmer, happier, pleasant, less/more, not as good, not as reliable, longer, more prolonged, and "goal not met" are not specific, measurable, or objective. These do not convey to the Medicaid consultant if or how much progress has been achieved. The following examples are specific, measurable and objective:

  Example 1: Strength increased from POOR to FAIR, as determined with a Manual Muscle Test.

  Example 2: Speech intelligibility improved from 30% to 70%, per standardized measurement.

- Consistent use of the same tests and measurements and units of measurement.

  Example: A progress statement that notes the recipient can now eat hamburgers does not correlate to his goal of articulation and the baseline established for articulation.

- *Progress must demonstrate the recipient has learned new skills and therefore has advanced or improved in function as a result of treatment intervention*. "If treatment of underlying factors, such as increase in endurance, strength or range of motion or decrease in pain does not improve the performance of functional activities, then improvement is not considered to be significant." (Acquaviva, p. 85).

  "Significant functional progress: Must result from treatment rather from maturation or other uncontrolled factors, must be real, not random, must be important, not trivial" (Bain and Dollaghan).
  - Significant functional progress must have been demonstrated within the past 6 months for continued therapy PA approval. Prior authorization requests for treatment that has not advanced or improved function within six months cannot be approved, HFS 107.16(3)(e)1, HFS 107.17(3)(e)1, and HFS 107.18(3)(e)1, Wis. Admin. Code.
  - Prior authrorization requests for maintenance therapy must demonstrate the functional purpose (medical necessity) of treatment, as "progress" is not necessarily applicable to maintenance programs. The Medicaid consultant will look for evidence that there is a continued functional purpose for the recipient as a result of skilled therapeutic intervention, in accordance with the Wisconsin Administrative Code and the July 2000, *Wisconsin Medicaid and BadgerCare Update* (2000-24), titled "Prior Authorization for Maintenance Therapy."

SECTION G. PLAN OF CARE

INSTRUCTIONS: Identify the specific, measurable, objective, and functional goals for the recipient (to be met by the end of this PA request); and
(1) the therapist required skills/treatment techniques that will be used to meet each goal; and
(2) designate (with an asterisk[*]) which goals are reinforced in a carry over program.

(If the plan of care is concisely written in other documentation prepared for the recipient's records, attach and write "see attached" in the space provided.)

Examples for this section include:
1. GOAL: Client will be 80% intelligible in conversation as judged by an unfamiliar listener.
   POC: Oral motor exercises, environmental cues, articulation skills.
2. GOAL: Client will increase vocabulary with five new words as reported by parent.
   POC: Sing songs, read books, use adjectives and adverbs in conversation.*
3. GOAL: Client will ascend stairs reciprocally without assistance.
   POC: Gastrocnemius and gluteus medius strengthening.
4. GOAL: Client will transfer into and out of tub with verbal cues.
   POC: Prepare bathroom and client for transfer, provide consistent verbal cues as rehearsed in PT.*
5. GOAL: Client will demonstrate ability to button ½-inch button on dress shirt independently using any pinch pattern.
   POC: Graded finger grasp/pinch strengthening, eye-hand coordination, and bilateral hand use.
6. GOAL: Client will catch/throw a 10" ball.
   POC: Practice play catch while sitting using a variety of objects, e.g., Nerf ball, plastic ball, beach ball, volleyball, balloon.*

It is very important to:
- Use consistent units of measurement.
- Document those elements of a treatment plan that only a skilled therapist could implement (e.g., 1, 3, and 5 above)
- Designate (with an asterisk [*]) those goals or interventions you have instructed other caregivers or the recipient to incorporate into the recipient's usual routine in their usual environment (such as 2, 4, and 6 above where kicking a ball, jumping, throwing a ball, building endurance, rote activities, who/what/where questions, using appropriate pronouns, choosing new foods, etc., are part of the overall plan of care)
- Write goals consistent with functional limitations and identified deficit as described in the evaluation and status statements (Section E) or progress section (Section F).

  Example: The evaluation identified the functional limitation and deficits corresponding to the above examples.
  Examples of limitations and deficits may include:
  1. The client is not intelligible in conversation due to poor tongue control.
  2. The 24-month-old client cannot express his needs because he has the vocabulary of a 16-month-old.
  3. The client cannot get to his bedroom independently because of POOR muscle strength.
  4. The client cannot safely get into the bathtub because he has poor short-term memory and is easily distractible.
  5. The client cannot dress independently because of decreased fine-motor skills as tested on the Peabody and he lacks all functional pinch patterns.
  6. The client cannot use hands/arms bilaterally because of poor left upper-extremity proximal stability.

SECTION H. REHABILITATION POTENTIAL

INSTRUCTIONS: Complete the following sentences based upon the professional assessment.

(1) Upon discharge from this episode of care, the recipient will be able to

Describe what the recipient will be able to FUNCTIONALLY *DO* at the end of this episode of care (not necessarily the end of the PA request), based upon the professional assessment. Discharge planning begins at the initial evaluation. At the initial evaluation the therapist should be able to determine the amount/type of change the recipient is capable of making based upon all the factors presented at the evaluation. Statements such as "will be age appropriate," "will resume prior level of function," "will have effects of multiple sclerosis minimized," or "will eat all foods" are vague and frequently are not achievable with the patient population therapists encounter. More recipient specific or definitive statements of prognosis would be the following examples:

- "Return to home to live with spouse support."
- "Communicate basic needs and wants with her peers."
- "Go upstairs to his bedroom by himself."
- "Get dressed by herself."
- "Walk in the community with stand-by assistance for safety."
- "Walk to the dining room with or without assistive device and the assistance of a nurse's aide."
- "Swallow pureed foods."

(2) Upon discharge from this episode of care, the recipient may continue to require the following supportive services

Indicate what community or therapy services the recipient may continue to require at the end of this episode of care. Examples include:

- "Range of motion program by caregivers."
- "Infrequent (be specific) screening by therapist to assure maintenance of skills."
- "A communication book."
- "Behavior management services."
- "Dietary consultation."
- "Supervision of <a task> by a caregiver."

(3) The recipient/recipient's caregivers support the therapy plan of care by the following activities and frequency of carryover

Describe what activities the recipient and/or caregivers do/don't do with the recipient that will affect the outcome of treatment.

(4) It is estimated this episode of care will end (provide approximate end time)

Establish an anticipated time frame for the recipient to meet his/her realistic functional goals (e.g., two weeks, two months, two years).

These specific questions are asked to avoid one-word responses (e.g., "good"). Information beyond a one-word response provides the Medicaid consultant with additional detail that supports the justification that therapy services are necessary to meet the recipient's goals. Wisconsin Medicaid recognizes the statements in this section are considered professional judgments and may not reflect the actual outcome of treatment.

SIGNATURES

The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by Wisconsin Medicaid indicating the physician's signature is acceptable). The providing therapist's signature is required at the end of the PA/TA. The recipient's, or recipient's caregiver, signature is optional at this time, but is encouraged (as a means to review what has been requested on the recipient's behalf on the PA request).

If the required documentation is missing from the request form, the request is returned to the provider for the missing information.

REMINDER: The prior authorization request must be filled out completely (i.e., all sections completed). Attach the completed PA/TA and any other documentation to the PA/RF.

REFERENCES

Bain and Dollaghan (1991). Language, Speech and Hearing Services in Schools, 13

Acquaviva, J.D., ed. (1992). Effective Documentation for Occupational Therapy. Rockville, Maryland, The American Occupational Therapy Association, Inc.

Moyers, P.A. (1999). “The Guide to Occupational Therapy Practice.” American Journal of Occupational Therapy (Special Issue), 53 (3)

American Physical Therapy Association, 2001, Guide to Physical Therapist Practice, Physical Therapy, 81 (1)

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American Occupational Therapy Association Standards of Practice

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